Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA SURGICAL CENTER WEST
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-04-B476-01

MFDR Date Received
July 23, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "reimbursement should be in an amount which is the applicable Medicare reimbursement rate at the time of the date of service multiplied by 213.3% to 290% depending on the complexity of the procedure performed. In the case of outliers, greater reimbursement should be allowed. The amount of reimbursement based on this formula is $1,087.83."

Amount in Dispute: $3,626.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the requester failed to produce any evidence that tits billing for the disputed procedures is fairy and reasonable. . . . this carrie's payment is consistent with fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code; . . . Medicare fair and reasonable reimbursement for similar or same facility services is below this carrier's, and . . . the Commission has concluded that charges cannot be validated as true indicators of the facility's costs."

Response Submitted by: Texas Mutual Insurance Company, 221 W. 6th St., Ste. 300, Austin, Texas 78749

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2004	Ambulatory Surgical Services	$3,626.39	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M – No MAR
   - T2 – REDUCTION WAS MADE ON OUTPATIENT BILL
   - F – Fee guideline MAR reduction
   - 66 – PAYMENT IS CONSISTENT WITH THE FEE SCHEDULE GUIDELINES FOR REIMBURSEMENT OF MULTIPLE SURGICAL PROCEDURES PERFORMED ON THE SAME DATE.
   - D – Duplicate bill
   - 60 – THE PROVIDER HAS BILLED FOR THE EXACT SERVICES ON A PREVIOUSBILL.
   - O – Denial after reconsideration
   - YO – REIMBURSEMENT WAS REDUCED OR DENIED AFTER RECONSIDERATION OF TREATMENT/SERVICE BILLED.
   - G – Unbundling
   - YG – REIMBURSEMENT FOR THIS PROCEDURE IS INCLUDED IN THE BASIC ALLOWANCE FOR ANOTHER PROCEDURE.

Findings

1. The respondent's position statement raises new denial reasons or defenses that were not presented to the requestor prior to the filing of this medical fee dispute. Per 28 Texas Administrative Code §133.307(j)(2), effective January 1, 2003, 27 *Texas Register* 12282, "The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of a request. Any new denial reasons or defenses raised shall not be considered in the review." Accordingly, any newly raised denial reasons or defenses shall not be considered in this review.
2. This dispute relates to services with reimbursement subject to former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "reimbursement should be in an amount which is the applicable Medicare reimbursement rate at the time of the date of service multiplied by 213.3% to 290% depending on the complexity of the procedure performed. In the case of outliers, greater reimbursement should be allowed. The amount of reimbursement based on this formula is $1,087.83."
   - No documentation was submitted to support the Medicare rate calculation for the services in dispute.
   - While the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients (22 *Texas Register* 6284), Texas Labor Code §413.011(b) requires that "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d). . . . This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services." The Division cannot therefore favorably consider a reimbursement based solely on the Medicare fee schedule reimbursement amounts.
   - The requestor did not discuss or provide documentation to support the complexity of the procedure performed or explain how that complexity should be considered in selecting a specific payment adjustment factor from within the proposed range.
   - The requestor did not explain or provide documentation to support how a specific payment adjustment factor amount should be selected from within the proposed range.

- In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	November 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.